

KING COUNTY SUPERIOR COURT  
*Juvenile Court Services*

**JUVENILE TREATMENT SERVICES/JUVENILE JUSTICE ASSESSMENT TEAM REFERRAL FORM**

<b>Referral Date:</b>	<b>Next Court Hearing Date:</b>	<b>Hearing Type:</b>	<b>Court Room:</b>
<b>Type of Assessment requested:</b> <input type="checkbox"/> Drug Alcohol Assessment <input type="checkbox"/> Mental Health Assessment <input type="checkbox"/> Psychological Evaluation <input type="checkbox"/> Psychiatric Consult <input type="checkbox"/> JJAT Consult <input type="checkbox"/> N/A – Assessment not requested	<b>Special Issues:</b> <input type="checkbox"/> Drug Court <input type="checkbox"/> ARY <input type="checkbox"/> CDDA/Committable <input type="checkbox"/> CHINS <input type="checkbox"/> Mentor <input type="checkbox"/> Diversion	<b>Special Issues:</b> <input type="checkbox"/> MHDA <input type="checkbox"/> Detention Clinic Referral <input type="checkbox"/> CDDA/Local Sanction <input type="checkbox"/> Other _____	<b>Youth's Location:</b> <input type="checkbox"/> Community <input type="checkbox"/> Detention <input type="checkbox"/> Other _____

<b>Youth's Name:</b> ( Last, First, Middle)			
<b>DOB:</b>	<b>Age:</b>	<b>Race/Ethnicity:</b>	<b>Gender:</b>
<b>Address:</b>			<b>Phone:</b>
<b>Parent/Guardian Name(s):</b>			
<b>Address:</b> (if different from youth)			<b>Phone:</b>

<b>JUVIS #:</b>	<b>JCN #:</b>	<b>Restitution:</b>	<b>Risk Level:</b> (if available)	
<b>Cause #(s):</b>	<b>Charge(s):</b>	<b>Is youth enrolled in school?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<b>Is youth attending school?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<b>Highest Grade completed:</b>		
		<b>Is family aware of referral?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<b>Is youth receptive to referral?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<b>Is family receptive to referral?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>Youth's primary language:</b>	<b>Interpreter needed:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is youth Medicaid eligible?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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Interested Parties	Address	Phone#	Fax #	Email address
<b>JPC:</b>				
<b>JCS Case Mgr:</b>				
<b>Attorney:</b>				

<b>Referral made by:</b>			
<b>Name:</b>	<b>Address:</b>	<b>Phone:</b>	<b>Email address:</b>
<b>Notes/Comments:</b> Why are you making this referral at this time? (add additional pages if necessary)			

Email substance abuse referrals to Karen Lanpher [karen.lanpher@kingcounty.gov](mailto:karen.lanpher@kingcounty.gov) or fax to 206-205-9414.  
 Email mental health, psychological, co-occurring disorders referrals to William Schipp  
[william.schipp@kingcounty.gov](mailto:william.schipp@kingcounty.gov) or call 206-205-9737.